FFY05-07 State Plan Modification

The South Dakota Division of Mental Health attended the CMHS Peer Review in Chicago, Illinois on October 18-19, 2004. During this review, the Division was asked to make 2 modifications to our Adult State Plan, and 2 modifications to the Children's Plan before CMHS would give final approval of our multi-year State Plan for CMHS Block Grant funding.

Adult Plan

The following information is broken out by each specific modification requested.

I. Additional information regarding medical, dental, rehabilitation and educational services.

The Division of Mental Health works with community mental health centers to include the provision of these services within the CARE Program services provided to individuals with severe and persistent mental illness. CARE staff work with individuals through regular referral/contact with agencies such as Vocational Rehabilitation, and consumer's primary health care physician and/or dentist. The CARE team addresses needs of consumers on an individual basis and referrals and linkage with other systems are contained within the treatment planning for that individual. For example, Community Counseling in Huron accompanies individuals to medical appointments and has the primary health care provider provide information and sign a form that then is included in that individual's mental health center chart. This way the information is shared between all providers, thereby better ensuring consumers are receiving most appropriate care through all areas of their life. Community Counseling Services also uses a Wellness Curriculum program that provides education to consumers on exercise, nutrition, understanding diagnoses and maintaining a healthy lifestyle.

CARE staff also work very closely with the Division of Rehabilitation Services. This relationship involves both agencies collaborating with consumers in providing options for employment, education and benefits planning. Several community mental health centers have vocational counselors located within their agencies, which allows for better coordinated services. The Division of Rehabilitation Services (DRS) also purchases services from community mental health centers to provide job development and job supports at the employment placement. As well as employment assistance, DRS will assist consumers with furthering education to include GED's and college degrees.

II. Additional information regarding achieving targets for each year in its 3 year plan.

This modification will be broken out by each performance indicator and more specific information for achieving targets in each of the three years.

A. Reduced utilization of psychiatric inpatient beds.

FY05-07 targets were set at 8% for each year due to the low rate of past readmissions within 30 days. It also seems to be realistic to maintain this number over the next 3 years. FY05-07 targets for readmissions within 180 days were set in a similar manner. Maintaining the low 30 day readmission and reducing the 180 day readmission will be accomplished through the continued efforts of the Discharge Planning workgroup, which consists of membership by the Division of Mental Health, the Human Services Center and representatives from the community mental health centers.

B. Evidence Based Practices—Number of persons receiving evidence based practices through ACT.

Over the three years of the grant period, the Division of Mental Health will work very closely with IMPACT programs statewide to explore the opportunities for increasing access to this evidence based practice statewide. Currently, the State run IMPACT program is further refining a Step-Down program that will allow them to step down individuals to a lesser intense service—if those individuals no longer demonstrate a need for very intense services. During FY06, the Division is looking to expand the Step-Down Program to all IMPACT programs across the state. The IMPACT Program and the local community mental health center will have regular meetings that will include case discussions and presentations of individuals that may meet criteria to be "Stepped-down" out of IMPACT services. If individuals can be identified as no longer needing IMPACT services, this may help to increase statewide access to other individuals needing the intense services provided through IMPACT. The Division of Mental Health will also monitor the number of consumers served and work with IMPACT programs to find ways to serve additional individuals if the step-down to the CARE program is not effective. Another possibility that has been discussed and that will continue to be explored throughout FY06-07 is the possibility of stepping individuals down in the services they receive within the IMPACT programs.

C. Evidence Based Practices—Number of persons with SPMI receiving evidence-based practice of Integrated Treatment.

This performance indicator is based on the one program South Dakota has that provides integrated substance abuse and mental health treatment for individuals with co-occurring disorders of mental illness and substance abuse. As this is a single program, the capacity is limited, however, the Division of Mental Health

will continue to monitor the program to ensure admissions and outcomes remain constant during FY05-07.

D. Client perception of Care—Number of consumers reporting positively about outcomes.

The Division of Mental Health has recognized this indicator as very important in the development of systems of care and the transformation of the mental health system toward recovery. The Division will be working closely with the community mental health centers to develop systems that will allow an increase in positive outcomes. During FY05, the CMT will add members who represent the clinical directors for adult services in those agencies who's current representative is a children's clinical director only. Discussions will begin regarding ways to implement recovery-based services across the community mental health center system. During FY06, trainings regarding recovery and services that focus on recovery will be held for all CMHC staff. More advanced training and education will occur throughout FY07 as well. These trainings will include things such as individualized planning for every consumer and their active involvement in such planning and the importance work and independent living have on assisting individuals in achieving recovery. The DMH anticipates these trainings and the move toward recovery services will lead to more positive outcomes being reported by consumers. The DMH will also monitor this indicator on a yearly basis and provide individual follow-up with those agencies who may be struggling to meet the increase.

E. Percentage of consumers receiving CMHC services who report they are working.

The Division of Mental Health feels that employment is an important part of the recovery process. For the FY2005-2007 time frame of the grant, the Division will be continuing the MHSIP survey and setting the goal of increasing numbers of consumers employed by 10% over the current number reported. Employment for individuals with a mental illness is a very important component of the recovery process. Processes and timelines identified in D. above will also assist in meeting the targets for this performance indicator.

F. Percentage of consumers receiving CMHC services who report participation in treatment planning.

Participation in treatment planning has been recognized by the Division of Mental Health and the Advisory Council as one of the highest priorities in the transformation of the mental health system towards recovery. Currently, 64.6% of consumers surveyed report

positively about participation in treatment planning. The Division and the Advisory Council together have set our goal to increase to 100% over the three years of the grant. The Division of Mental Health will be conducting the MHSIP survey on an annual basis, and working closely with the community mental health centers on development of systems of care to help achieve this goal. The Division of Mental Health has refined the CMHC accreditation process to include more consumer/family involvement as well as basing accreditation on outcome data rather than administrative data. This process will continue to be refined throughout FY05. Further revision that may be needed through discussions with CMHC staff and consumers/family members will occur through FY06. During FY05-07, the Division will also conduct individual agency follow-up surveys/processes to better understand barriers to meeting this goal, along with looking at additional ways of measuring this indicator.

G. Percentage of consumers receiving CMHC services who report increased levels of functioning and Percentage of consumers who report living independently.

The Division of Mental Health has compared results from four years of conducting the MHSIP survey and the positive responses to high levels of functioning and living independently has remained constant. During the FY05-07 time frame of the grant, the Division will be looking to increase this number slightly over current levels. This indicator is very important in the transformation of the mental health system towards recovery. This will be accomplished through close collaboration with community mental health centers and development of systems of care statewide, and conducting the MHSIP survey on an annual basis.

H. Percentage of consumers receiving CMHC services who report involvement in the criminal justice system during the last year.

The Division of Mental Health was granted the Data Infrastructure Grant (DIG) on Quality Improvement. In FY05 the DIG will assist the Division in developing local infrastructure to capture needed data elements for measuring criminal justice involvement. In FY05, the Division will be contracting with the Bristol Observatory to combine data from the mental health MIS and the DOC MIS to provide more accurate data on involvement with the criminal justice system. In FY06, the Division of Mental Health will be reporting on the URS table 19 on criminal justice involvement. In FY07, this process will continue with further refinements of data collection and analysis. The Division of Mental Health will also continue through FY05-07 to conduct the Youth

MHSIP survey. This more accurate data will result in the Division having a better ability to develop solutions. Our current level is 23%, and the Division is looking to decrease that percentage by 4% over the next three years.

I. Increased access to services—Number of persons with SPMI, Number of adults with SPMI receiving publicly funded services in catchment areas that are predominately frontier and the Average amount of public funds expended on mental health services for adults with SPMI.

The increase in target numbers is based on historical inflationary increases in budget numbers at the end of FY06. Due to limited funding, the increases in numbers served through the community mental health system are not dramatic. Over the next three years, the Division will continue to explore additional funding options to increase access to services for individuals statewide.

J. Number of adults who are homeless, or at risk of homelessness, receiving PATH housing funds.

South Dakota is a minimum allotment state for PATH funding. The Division of Mental Health does not foresee an increase in this funding, and with limited funding available in other areas, the Division will look at increasing the numbers served only slightly over FY05-07.

Children's Plan

I. Additional information regarding integrating services for children, especially social services, education, juvenile justice and IDEA.

The children's SED program is an intensive and comprehensive, child-centered, family-focused, community-based, individualized system of care that delivers mental health services to children with SED. This program provides access to a comprehensive array of services that address a child's physical, psychological, emotional, social and educational needs. Parents, families and other child-serving agencies are participants in all aspects of the evaluation, planning and delivery of SED services. A case manager is assigned to the child/family to access and coordinate benefits on behalf of the family. The case manager partners with the family to complete many activities. These include: identification of child and family needs and strengths; creation of a strength-based, outcome-focused treatment plan using a team approach involving the child, family and all other involved service providers; assistance to the family in accessing other resources in the community such as substance abuse agencies or primary healthcare physicians; advocating on behalf of the family and child; and, coordination of services on behalf of the family within the mental health center and with other child-serving agencies in the community, including schools, Department of Social Services, Department of Corrections, Child Protection Services, and other agencies.

Part of these case management services may include employment services, if an adolescent desires employment. Such services might include assisting the individual in locating, securing and maintaining employment or assisting the individual in accessing services through other agencies or programs. An example of linking individuals to another agency would be through a program called "*Project Skills."* The State Vocational Rehabilitation Agencies, Division of Rehabilitation Services and Services to Blind and Visually Impaired, fund this program to address the need for students with disabilities to get an opportunity to gain paid employment while in high school. Project Skills is a cooperative arrangement between the State VR agencies and the local school systems. The State VR agencies fund the wages, workers compensation and FICA while the schools provide the job development, job coaching and follow-along for the student at the job site. This allows students with disabilities to take advantage of an important learning, maturing and socializing experience.

Section II: Children's Mental Health System of the original application contains extensive information regarding Division of Mental Health efforts to work towards more integrated services for children on an administrative level. Some activities include the following:

1) The Unified Judicial System (UJS) and community mental health center directors have collaborated to improve the referral and service delivery system for children who are referred by UJS to a community mental health center. A memorandum of understanding (MOU) has been drafted and addresses the following: 1) procedures for transacting standardized referrals for children's mental health services from the courts to respective community mental health centers; 2) practices for minimizing "no shows" among referred children/families; and 3) principles for assuring effective co-management of referred children and families. In addition, Child Protective Services (CPS), community mental health center directors, and the Division of Mental Health began working in FY04 to establish more coordinated services for children referred by CPS. An MOU was also developed and implemented that addresses the following: 1) the development of a uniform intake/referral process for mental health services; 2) the development of a uniform referral/follow-up process for child abuse assessments; 3) the adoption of principles for the co-management of referrals; and 4) the identification of service gaps. These MOU's will be implemented on a local level between CPS/UJS offices and local community mental health centers.

2) Also with CPS, the Division of Mental Health has collaborated to offer mental health services targeted to families with children who are at risk of being removed from their families by CPS. Northeastern Mental Health Center and Southeastern Behavioral HealthCare are the two pilot sites for this effort. The local CPS offices identify children that have been already removed from the home or are at risk of being removed. CPS then contacts the Northeastern or Southeastern children's staff to provide home-based mental health services in an attempt to keep the child in the home or to reunify the family if the child has already been removed. It is planned in future years to expand this program across the state as funding and needs dictate.

3) The South Dakota Council of Mental Health Centers secured a grant in the fall of 2003 from the Office of Juvenile Justice and Delinquency Prevention to provide integrated and enhanced services to at-risk youth and families residing in South Dakota's most "difficult to reach" locations. Grant supported activities will target youth who are already involved or at risk of involvement with the state's juvenile justice system. Ten mental health centers across the state have children's staff that work with DOC staff to identify these youth and provide one or more of the following services to these youth and their families: 1) wraparound services, 2) school-based/linked mental health services, 3) community development/coordination projects; and 4) professional training/development for rural/frontier service providers.

4) The community mental health centers work closely with other community agencies and schools in providing information regarding mental health services, as well as, in some areas of the state, providing mental health services within the schools themselves. Community mental health centers work very closely with school personnel in identification and early intervention for children identified through IDEA as having a serious emotional disturbance. For example, Southern Plains Behavioral Health Services works very closely with school counselors and teachers to provide early interventions and developing systems of care for youth in their

communities. Southern Plains staff also work closely with youth, families and IEP teams to not only ensure that needed mental health services are being provided, but also that the child is receiving appropriate education, despite mental health issues or other learning disabilities. Community mental health center staff are very involved in development of IEP's, groups such as life skills and building self esteem, and education for youth, teachers and counselors regarding identification and interventions.

5) The Intensive Family Services (IFS) Program is provided jointly by the Departments of Corrections, Labor, Social Services and Human Services. This pre-aftercare program is a multidimensional effort to provide an opportunity to families of youth who are placed under the jurisdiction of the Department of Corrections to address issues and access needed services to allow their children to return to their homes with the greatest opportunity for success. Referrals are initiated by the Department of Corrections, Juvenile Corrections Agent (JCA). The DOC submits a referral to the Department of Social Services, who in turn completes a functional assessment with the family. A portion of this assessment includes a brief mental health screen. If certain criteria are met through that screen the referral is sent to the Division of Mental Health for review. If deemed an appropriate referral, it is then sent to the community mental health center that covers the area where the family live. The mental health center then does a complete assessment with the family to determine level of services needed. The community mental health center then provides home-based mental health services to that family in preparation for the youth returning from DOC custody.

II. Additional information regarding achieving targets for each year in its 3 year plan.

A. Reduced Utilization of Psychiatric Inpatient Beds.

FY05-07 targets were set at .5% for each year due to the low rate of past readmissions within 30 days. It also seems to be realistic to maintain this number over the next 3 years. FY05-07 targets for readmissions within 180 days were set in a similar manner. Maintaining the low 30 day readmission and reducing the 180 day readmission will be accomplished through the continued efforts of the Discharge Planning workgroup, which consists of membership by the Division of Mental Health, the Human Services Center and representatives from the community mental health centers.

B. Number of youth reporting positively about outcomes

The Division of Mental Health feels that outcomes are very important in development of systems of care and the transformation of the mental health system to recovery. The Division of Mental Health will be working closely with the community mental health centers to develop systems that will

allow an increase in positive outcomes. In FY04, the State had a kick off training for CMHC children staff regarding systems of care. In FY05 and 06, trainings will continue in the area of implementation of recovery-based services across the community mental health system. More advanced training and education will occur throughout FY07 as well. These trainings will include such things as intensive case management, family-focused services, strength-based services and individual planning. The DMH anticipates these trainings and the move toward recovery will lead to more positive outcomes being reported by consumers. The DMH will also monitor this indicator on a yearly basis and provide individual follow-up with those agencies who may be struggling to meet the increase.

C. Percentage of youth receiving CMHC services who report participation in treatment planning.

Participation in treatment planning has been recognized by the Division of Mental Health and the Advisory Council as one of the highest priorities in the transformation of the mental health system towards recovery. Currently, 72.7% of consumers surveyed report positively about participation in treatment planning. The Division and the Advisory Council together have set our goal to increase to 100% by over the three years of the grant. The Division of Mental Health will be conducting the Youth MHSIP Survey on an annual basis, and working closely with the community mental health centers on development of systems of care to help achieve this goal. The Division of Mental Health has refined the CMHC accreditation process to include more consumer/family involvement as well as basing accreditation on outcome data rather than administrative data. This process will continue to be refined throughout FY05. Further revision that may be needed through discussions with CMHC staff and consumers/family members will occur through FY06. During FY05-07, the Division will also conduct individual agency follow-up surveys/processes to better understand barriers to meeting this goal, along with looking at additional ways of measuring this indicator.

D. Percentage of youth receiving CMHC services who report increased levels of functioning.

The Division of Mental Health has compared results from four years of conducting the MHSIP survey and the positive responses to high levels of functioning have remained constant. During FY05-07, the Division will be looking to increase this number slightly over current levels. This indicator is very important in the transformation of the mental health system towards recovery. This will be accomplished through processes identified in B. above,

plus close collaboration with community mental health centers and development of systems of care statewide, and conducting the MHSIP survey on an annual basis.

E. Percentage of youth receiving CMHC services who report their families are receiving services from CMHC.

This performance indicator was not measured in the past. The Division feels that family involvement with services is vital to positive outcomes for youth receiving mental health services. Due to this importance, the Division of Mental Health has set targets for this indicator very high, with 94.7% being the target for FY2007. The Division of Mental Health will monitor through annual Youth MHSIP surveys as well as during accreditation reviews with community mental health centers over the next three years. Throughout FY-05-07 trainings for CMHC staff will continue in the areas of systems of care, with one of the priorities being on family-focused services.

F. Percentage of youth receiving CMHC services who report involvement in the juvenile justice system.

The Division of Mental Health was granted the Data Infrastructure Grant (DIG) on Quality Improvement. In FY05 the DIG will assist the Division in developing local infrastructure to capture needed data elements for measuring criminal justice involvement. In FY05, the Division will be contracting with the Bristol Observatory to combine data from the mental health MIS and the DOC MIS to provide more accurate data on involvement with the criminal justice system. In FY06, the Division of Mental Health will be reporting on the URS table 19 on criminal justice involvement. In FY07, this process will continue with further refinements of data collection and analysis. The Division of Mental Health will also continue through FY05-07 to conduct the Youth MHSIP survey. This more accurate data will result in the Division having a better ability to develop solutions. Our current level is 23%, and the Division is looking to decrease that percentage by 4% over the next three years.

G. Increased access to Services—Number of persons with SED and Average amount of public funds expended on mental health services for children with SED.

The increase in target numbers is based on historical inflationary increases in budget numbers at the end of FY06. Due to limited funding, the increases in numbers served through the community mental health system are not dramatic. Over the next three years, the Division will continue to explore additional funding options to increase access to services for individuals statewide.

H. Number of children who are homeless, or at risk of homelessness, receiving PATH housing funds.

South Dakota is a minimum allotment state for PATH funding. The Division of Mental Health does not foresee an increase in this funding, and with limited funding available in other areas, the Division will look at increasing the numbers served only slightly from FY05-07.